STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
BOARD OF MEDICINE

Final Order No. AHCA-95-01289 Date 9-19-95
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Agency for Health Care Administration
AGENCY CLERK
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By: Brandon H. Moore
Deputy Agency Clerk

AGENCY FOR HEALTH CARE ADMINISTRATION, BOARD OF MEDICINE,

Petitioner,

v.

AHCA CASE NO: 0106456
DOAH CASE NOS: 93-2858
LICENSE NO: ME 0004260

MICHAEL M. GILBERT, M.D.,

Respondent.
_____/

FINAL ORDER

THIS MATTER was heard by the Board of Medicine (hereinafter Board) pursuant to Section 120.57(1)(b)10., Florida Statutes, on August 4, 1995, in Palm Beach Gardens, Florida, for consideration of the Hearing Officer's Recommended Order, the Respondent's Exceptions and Petitioner's Response thereto (Attached as App. A, B and C, respectively) in the case of Agency for Health Care Administration, Board of Medicine v. Michael M. Gilbert, M.D. Petitioner was represented by Larry G. McPherson, Jr., Chief Medical Attorney. Respondent was present and represented by Joseph Paglino, Esquire. Upon consideration of the Hearing Officer's Recommended Order after review of the complete record and having been otherwise fully advised in its premises, the Board makes the following findings and conclusions:

RULINGS ON PETITIONER'S COMBINED EXCEPTIONS TO FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Respondent's first Exception to any Finding of Fact or Conclusion of Law of the Hearing Officer that the Respondent treated Patient #1 for pain in the right hip and right leg, is rejected. For reasons stated in the Petitioner's Response, there was competent substantial evidence to support this finding.

2. Respondent's second Exception to any Finding of Fact or Conclusion of Law of the Hearing Officer that the Respondent on or about March 26, 1984, Respondent diagnosed Patient #1 as suffering from post-Concussion Syndrome, is accepted, based upon the Board's review of the medical records. The last sentence of paragraph 13 of the Findings of Fact of the Recommended Order is rejected.

3. Respondent's third Exception to any Finding of Fact or Conclusion of Law of the Hearing Officer that the Respondent failed to maintain adequate medical records of Patient #1, is rejected. For reasons stated in the Petitioner's Response, there was competent, substantial evidence to support this Finding of Fact. It is well settled that the Board cannot reject findings of fact where there is competent, substantial evidence to support those finding. See McDonald v. Dept. of Banking and Finance, 346 So. 2d 569 (Fla. 1st DCA 1977).

4. Respondent's fourth Exception to any Finding of Fact or Conclusion of Law of the Hearing Officer that the medical records of Patient #1 did not justify the diagnosis of post-concussion syndrome, is rejected. For reasons stated in the Petitioner's

Response, there was competent, substantial evidence to support this Finding of Fact. It is well settled that the Board cannot reject findings of fact where there is competent, substantial evidence to support those finding. See McDonald v. Dept. of Banking and Finance, 346 So. 2d 569 (Fla. 1st DCA 1977).

5. Respondent's fifth Exception to any Finding of Fact or Conclusion of Law of the Hearing Officer that the Respondent improperly recommended or treated Patient #1 with carbon dioxide treatments, is rejected. For reasons stated in the Petitioner's Response, there was competent, substantial evidence to support this Finding of Fact. It is well settled that the Board cannot reject findings of fact where there is competent, substantial evidence to support those finding. See McDonald v. Dept. of Banking and Finance, 346 So. 2d 569 (Fla. 1st DCA 1977).

6. Respondent's sixth Exception to any Finding of Fact or Conclusion of Law of the Hearing Officer that carbon dioxide treatments was not an accepted treatment modality for Patient #1, is rejected. For reasons stated in the Petitioner's Response, to include expert witness testimony, there was competent, substantial evidence to support this Finding of Fact. It is well settled that the Board cannot reject findings of fact where there is competent, substantial evidence to support those finding. See McDonald v. Dept. of Banking and Finance, 346 So. 2d 569 (Fla. 1st DCA 1977).

7. Respondent's seventh Exception to any Finding of Fact or Conclusion of Law of the Hearing Officer that Respondent practiced below an acceptable standard of care with regard to Patient #1, is

rejected. For reasons stated in the Petitioner's Response, to include expert witness testimony, there was competent, substantial evidence to support this Finding of Fact. It is well settled that the Board cannot reject findings of fact where there is competent, substantial evidence to support those finding. See McDonald v. Dept. of Banking and Finance, 346 So. 2d 569 (Fla. 1st DCA 1977).

8. Respondent's eighth Exception to any Finding of Fact or Conclusion of Law of the Hearing Officer that Respondent misdiagnosed Patient #1 with post traumatic syndrome, is rejected. For reasons stated in the Petitioner's Response, to include expert witness testimony, there was competent, substantial evidence to support this Finding of Fact. It is well settled that the Board cannot reject findings of fact where there is competent, substantial evidence to support those finding. See McDonald v. Dept. of Banking and Finance, 346 So. 2d 569 (Fla. 1st DCA 1977).

9. Respondent's ninth Exception to any Finding of Fact or Conclusion of Law of the Hearing Officer that Respondent practiced below an acceptable standard of care or failed to maintain adequate medical records with regards to Patient #1, is rejected. For reasons stated in the Petitioner's Response, to include expert witness testimony, there was competent, substantial evidence to support these Findings of Fact and Conclusions of Law. It is well settled that the Board cannot reject findings of fact where there is competent, substantial evidence to support those finding. See McDonald v. Dept. of Banking and Finance, 346 So. 2d 569 (Fla. 1st DCA 1977).

10. Respondent's tenth Exception to any Finding of Fact or Conclusion of Law of the Hearing Officer that Respondent be disciplined for any matters set forth in the Amended Administrative Complaint, is rejected. For reasons stated in the Petitioner's Response, Florida Statutes provide for discipline based upon those violations alleged in the Amended Administrated Complaint.

11. Respondent's eleventh Exception to any Finding of Fact or Conclusion of Law of the Hearing Officer that would subject the Respondent to discipline, is rejected. For reasons stated in the Petitioner's Response, this summary, conclusory statement of the Respondent does not set forth a specific basis for the exception for the Board to decide.

12. Respondent's twelfth Exception to any Finding of Fact or Conclusion of Law of the Hearing Officer that his affirmative defenses are not legally sufficient, is rejected. For reasons stated in the Petitioner's Response, this summary, conclusory statement of the Respondent does not set forth a specific basis for the exception for the Board to decide.

13. Respondent's thirteenth Exception to any Finding of Fact or Conclusion of Law of the Hearing Officer that the Amended Administrative Complaint should not be dismissed based upon the Respondent's previous submitted motions, is rejected. For reasons stated in the Petitioner's Response, this is not an exception to a specific Finding of Fact or Conclusion of Law for the Board to decide.

14. Respondent's fourteenth Exception to any Finding of Fact

or Conclusion of Law of the Hearing Officer that the Respondent should not be awarded attorneys fees, is rejected. For reasons stated in the Petitioner's Response, this is without merit as attorneys fees may be awarded to the prevailing party in a case and the Respondent was not a prevailing party in this case nor is the case ripe for such decision nor is the request in the correct forum.

15. Respondent's fifteenth Exception to the Hearing Officer's rejection of any of Respondent's Proposed Finding of Fact, is rejected. For reasons stated in the Petitioner's Response, this is not an exception to a specific Finding of Fact or Conclusion of Law for the Board to decide. Further, there was competent and substantial evidence to support the Findings of Fact of the Hearing Officer.

16. Respondent's sixteenth Exception to the Hearing Officer's rejection of any of Respondent's Proposed Conclusion of Law, is rejected. For reasons stated in the Petitioner's Response, this is not an exception to a specific Conclusion of Law for the Board to decide. Additionally, the Conclusions of Law of the Hearing Officer are based upon Findings of Fact supported by competent and substantial evidence.

17. Respondent's seventeenth Exception to the Hearing Officer's finding that the Petitioner proved the essential elements of the Amended Administrative Complaint, is rejected. For reasons stated in the Petitioner's Response, the evidence presented at hearing was clear and convincing proof that the Respondent was in

violation of Chapter 458 as alleged in the Amended Administrative Complaint.

FINDINGS OF FACT

1. The Hearing Officer's Recommended Findings of Fact are approved and adopted and are incorporated herein by reference as the Findings of Fact of the Board in this cause.

2. There is competent, substantial evidence to support the Board's findings herein.

CONCLUSIONS OF LAW

1. The Board has jurisdiction over the parties and subject matter of this case pursuant to Section 120.57 and Chapter 458, Florida Statutes.

2. The Conclusions of Law of the Recommended Order are approved and adopted and incorporated herein.

RULING ON RESPONDENT'S EXCEPTION TO RECOMMENDED PENALTY

Respondent's Exception to any Recommended Penalty of the Hearing Officer that the penalty should not be applied retroactively to the date of the filing of the Amended Administrative Complaint, is rejected for reasons stated in the Petitioner's Response.

DISPOSITION

Based upon the Recommended Findings of Fact and Conclusions of Law, the Hearing Officer recommended the following penalty:

1. That the Respondent is guilty of violating Sections 458.331(1)(m) and (t), Florida Statutes as charged in Counts I and II of the Amended Administrative Complaint. Counts III and IV of

the Amended Administrative Complaint are dismissed.

In light of the foregoing Findings of Fact and Conclusions of Law the Board hereby determines that pursuant to Rule 59R-8, Florida Administrative Code, the penalty recommended by the Hearing Officer as set forth in the Recommended Order is excessive. The Board imposes the penalty as set forth below.

WHEREFORE, it is found, ordered and adjudged that the Respondent is guilty of violating Section 458.331(1)(m) and (t) of the Amended Administrative Complaint and Counts III and IV are dismissed and pursuant to Rule 59R-8, F.A.C., the Board of Medicine imposes the following penalty:

1. Respondent's shall receive a Letter of Concern.

3. The Respondent shall pay a fine of $1,000, within thirty (30) days of the filing of the Final Order in this cause.

This Final Order becomes effective upon its filing with the Clerk of the Agency for Health Care Administration.

NOTICE

The parties are hereby notified pursuant to Section 120.59(4), Florida Statutes, that an appeal of this Final Order may be taken pursuant to Section 120.68, Florida Statutes, by filing one copy of a Notice of Appeal with the Clerk of the Agency for Health Care Administration and one copy of a Notice of Appeal with the required filing fee with the District Court of Appeal within thirty (30) days of the date this Final Order is filed.

DONE and ORDERED this 14 DAY OF September, 1995.

BOARD OF MEDICINE

Gary E. Winchester, M.D.
GARY E. WINCHESTER, M.D.
CHAIRMAN

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order and its attachments have been forwarded by U.S. Mail to Michael M. Gilbert, M.D., 1250 N.W. 7th Street, Suite 201, Miami, Florida 33180, Joseph Paglino, Esquire, 11601 Biscayne Boulevard, Suite 301, North Miami, Florida 33181, J. Stephen Menton, Hearing Officer, The Desoto Building, 1230 Apalachee Parkway, Tallahassee, Florida 32399-1550 and by hand delivery to Larry G. McPherson, Jr., Chief Medical Attorney, Agency for Health Care Administration, 1940 North Monroe Street, Tallahassee, Florida 32399-0792 on this 19th day of September, 1995.

Marm Harris
Marm Harris, Ed.D.
Executive Director

STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION, BOARD OF MEDICINE, Petitioner,	)	
vs.	)	CASE NO. 93-2858
MICHAEL GILBERT, M.D., Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice, a formal hearing was conducted in this case on May 25 and 26, 1994, in Miami, Florida, before J. Stephen Menton, a duly designated hearing officer of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Arthur B. Skafidas, Esquire
Agency for Health Care Administration
1940 North Monroe Street
Suite 60
Tallahassee, FL 32399-0792

For Respondent: Joseph Paglino, Esquire
Suite 301
11601 Biscayne Boulevard
North Miami, Florida 33181

STATEMENT OF THE ISSUES

The issue in this case is whether disciplinary action should be taken against Respondent's license to practice medicine based upon the alleged violations of Section 458.331(1), Florida Statutes, set forth in the Amended Administrative Complaint filed by Petitioner.

PRELIMINARY STATEMENT

In a four count Amended Administrative Complaint dated August 25, 1992, Petitioner[1] charged Respondent with violating Sections 458.331(1)(m) and (t) in connection with his treatment of two patients identified as Patient No. 1 and Patient No. 2. (For purposes of this Recommended Order, Patient No. 1 will be referred to as "C.P." and Patient No. 2 will be referred to as "E.R."). Counts I and II charged Respondent with violating subsections (m) and (t) respectively in connection with his treatment of Patient C.P. Counts III and IV charged Respondent with violating the same statutory provisions in connection with his treatment of Patient E.R. Specifically, the Amended Administrative Complaint alleged that Respondent failed to keep adequate medical records justifying his course of treatment of the patients (Counts I and III); that Respondent misdiagnosed Patient C.P. as suffering from "post-concussion syndrome" and/or improperly treated the Patient with carbon dioxide treatment thereby falling below the standard of care expected of a reasonably prudent physician under similar circumstances (Count II); and that Respondent's evaluation of Patient E.R.'s EEG test was "unacceptable and below the standard of care" (Count IV).

Respondent denied the allegations of the Amended Administrative Complaint and timely requested a formal hearing. The case was referred to the Division of Administrative Hearings ("DOAH") which noticed and conducted the hearing. The case was heard consecutively with another proceeding involving Respondent, DOAH Case No. 93-5972.

The case was originally assigned to Hearing Officer William J. Kendrick. Prior to the hearing, Hearing Officer Kendrick ruled on several preliminary motions. At the outset of the hearing, the parties were advised that the rulings entered by Hearing Officer Kendrick would be considered the law of the case and would not be revisited.

One of the motions filed prior to the hearing was a Motion to Determine Reasonableness of Expert Fees (the "Fees Motion") filed by Petitioner. Hearing Officer Kendrick entered an order deferring ruling on the Fees Motion until the final hearing. The Fees Motion involved the expert witness fees for Dr. Basil Yates, an expert listed as a witness by Respondent. Dr. Yates was not present at the hearing. His deposition testimony was accepted into evidence. During the hearing, counsel for Respondent stated that he did not represent Dr. Yates and consequently would not address the issues raised in the Fees Motion. Subsequent to the hearing, a telephone conference hearing was conducted with Dr. Yates during which time Petitioner's tender of $350.00 to Dr. Yates for a one hour deposition was ruled to be reasonable.

During the hearing, Petitioner presented the testimony of three witnesses: Barbara O'Connor, records custodian for Plaza Medical Center; Jeffrey Matthews, an investigator employed by Petitioner; and Respondent. Petitioner had fourteen exhibits marked during the course of the hearing, ten of which were accepted into evidence. Respondent's objections to the deposition testimony of Petitioner's expert witnesses (Petitioner's Exhibits

9 and 10) were overruled. Petitioner's Exhibits 3, 4, 5 and 6 were not offered into evidence.

The authenticity and completeness of the medical records for the patients was the source of considerable argument and dispute between the parties. At the hearing, Petitioner was unable to provide authenticated medical records for E.R. or a valid release for those records. This shortcoming was discussed during the hearing. As set forth below, it is concluded that Petitioner has not met its burden of proof with respect to Counts III and IV of the Amended Administrative Complaint and these counts should be dismissed.

Petitioner's Exhibit 11 was an Authorization for Release of Medical Information purportedly signed by C.P. Petitioner objected to the admissibility of this document because C.P. was not present to testify and the release was not notarized. This objection was overruled at the hearing, but Respondent was granted an opportunity to submit additional argument on this point in his posthearing submittals. No persuasive objections to this exhibit have been provided by Respondent.

As set forth in an Order entered on July 11, 1994, evidence was presented during the course of the hearing regarding the unavailability of the original medical records of Patient C.P. Purported copies of those medical records were marked as Petitioner's Exhibit 5. However, those records were not authenticated and were not offered into evidence. Petitioner did offer into evidence the following: Petitioner's Exhibit 2, which

was an affidavit dated May 6, 1994 from an attorney for Plaza Medical Center regarding the unavailability of the original medical records for Patients C.P. and E.R.; Petitioner's Exhibit 12, which was an August 28, 1989 letter from an attorney for Plaza Medical Center responding to a subpoena issued during an investigation commenced by Petitioner; and Petitioner's Exhibit 13, which was a September 25, 1991 letter from the attorney for Plaza Medical Center attached to which was a September 13, 1991 Verification of Completeness of Records purportedly executed by the Records Custodian for Plaza Medical Center regarding the medical records for Patient C.P. Attached to the letter marked as Petitioner's Exhibit 12 were purported copies of the medical records of C.P. During the hearing, Petitioner's Exhibits 2, 12 and 13 were accepted to establish the documents received by the Department during the course of its investigation. Ruling on the admissibility of the Exhibits for other purposes was reserved and the parties were given an opportunity to address the legal issues surrounding the admissibility of those records in their proposed recommended orders.

Prior to filing a proposed recommended order, Respondent filed Respondent's Request for Ruling Denying Admission of the "Medical Records" of C.P. Subsequently, Respondent also filed Respondent's Motion for Extension of Time to File Proposed Findings of Fact and Conclusions of Law. Petitioner filed Petitioner's Response to Respondent's Request for Ruling Denying Admission of the "Medical Records" of C.P. and a Response to

Respondent Gilbert's Motion for Extension of Time to File Proposed Findings of Fact and Conclusions of Law. After these filings were reviewed and considered an Order was entered on July 11, 1994 accepting into evidence the medical records attached to Petitioner's Exhibit 12 under the authority of Garcia v. State, 564 So.2d 124, 126 (Fla. 1990) and ITT Real Estate Equities, Inc. v. Chandler Insurance Agency, 617 So.2d 750 (Fla. 4th DCA 1993).

At the hearing, Respondent testified on his own behalf, but did not present any other witnesses. Respondent had eight exhibits marked for identification during the course of the hearing and offered seven of them into evidence, all of which were accepted. Respondent's Exhibit 7 was not offered into evidence. Petitioner's objections to the deposition testimony of Respondent's expert witnesses (Respondent's Exhibits 2-5) were overruled. Similarly, Petitioner's objections to Respondent's Exhibit 1, a composite of several articles authored by Respondent regarding post-concussion syndrome and carbon dioxide treatments, were overruled.

The July 11, 1994 Order established a time frame for filing proposed findings of fact and conclusions of law. Both parties have timely submitted proposed findings of fact and conclusions of law in accordance with that schedule. A ruling on each of the parties' proposed findings of fact is included in the Appendix to this Recommended Order.

Subsequent to the filing of proposed findings of fact and conclusions of law, Respondent filed Respondent's Motion for

Attorney's Fees. That Motion did not cite to any specific statutory authority for an award of attorney's fees. Petitioner filed a Motion to Dismiss with respect to the Motion for Attorney's Fees arguing that any motion for attorney's fees was premature until this case was finally resolved. Respondent filed Respondent's Reply to Petitioner's Motion to Dismiss Petitioners [sic] Motion for Attorney [sic] Fees. That Response also fails to cite to any specific statutory authority for the award being sought. It is assumed that the motion was predicated upon Section 57.111, Florida Statutes. Such a motion is clearly premature until the case is finally resolved. Accordingly, Respondent's Motion is denied.

FINDINGS OF FACT

Based upon the oral and documentary evidence adduced at the final hearing and the entire record in this proceeding, the following findings and fact are made:

1. At all times pertinent to this proceeding, Respondent, Michael Gilbert, was a licensed physician in the State of Florida, having been issued license number ME0004260. Respondent was licensed as a physician in Florida sometime prior to 1973. Although no conclusive evidence was presented as to the exact date Respondent was first licensed, it appears that Respondent has been licensed since approximately 1949.

2. Respondent is Board Certified by the American Board of Psychiatry and Neurology. Respondent also holds a Ph.D. in Psychology and is a licensed Psychologist.

3. There is no evidence of any prior disciplinary action against Respondent except for the charges in DOAH Case No. 93-5972 which was heard immediately prior to the hearing in this case. A Recommended Order in that case has been issued this same date.

4. Based upon complaints received from an insurance company, the Department initiated an investigation regarding Respondent's treatment of Patient C.P. and at least one other patient in approximately October of 1988. The Department served a subpoena on Respondent seeking his medical records regarding the treatment of those patients. Through his attorney at the time, Respondent advised that he had seen the patients at Plaza Medical Center and not as private patients at his office and, thus, any records that existed would be located at Plaza Medical Center. The Department then issued a subpoena to the custodian of medical records at Plaza Medical Center seeking the records for Patient C.P. and others. Ultimately, the attorney for Plaza Medical Center provided the Department with the records which were attached to the letter marked as Petitioner's Exhibit 12.

5. At the time of the hearing in this case, the original medical records of Plaza Medical Center could not be located. As set forth in the Preliminary Statement above, the copies of the records which were attached to Petitioner's Exhibit 12 were accepted into evidence. Those records were produced by an attorney for Plaza Medical Center in response to the subpoena issued by Petitioner in 1989.

6. The evidence in this case clearly established that Respondent saw and evaluated Patient C.P. at Plaza Medical Center. Respondent has suggested that the records attached to Petitioner's Exhibit 12 were inaccurate and/or incomplete. No persuasive evidence was presented to establish that any pertinent parts of C.P.'s medical records were missing or altered.

7. Respondent has acknowledged preparing the handwritten entries on a form Psychiatric Examination and Evaluation Report contained in the medical records for C.P. which have been accepted into evidence. Moreover, the records accepted into evidence were apparently used as a basis for insurance billing. Respondent suggests that there may have been additional pages to his report which have not been included with the records. Even if this suggestion is true, Respondent was responsible for insuring that adequate medical records were kept regarding his examination and treatment of the Patient. As set forth below, Respondent has not met this responsibility.

8. Respondent claims that Plaza Medical Center was "like a clinic" and arranged patient appointments, provided billing services and other administrative services to physicians. Respondent claims he had a verbal contract to provide medical services to patients at Plaza Medical Center and was paid per patient seen. According to Respondent, Plaza Medical Center handled all of the insurance billing and record-keeping. Respondent claims that Plaza Medical Center was responsible for maintaining any and all records regarding his evaluation of and

any treatment rendered to Patient C.P. at Plaza Medical Center. Even if Respondent's version of his arrangement with Plaza Medical Center is accepted as accurate, Respondent still had an obligation to see that adequate medical records were kept regarding his examination and treatment of the Patient.

9. Respondent contends that at some point after Patient C.P.'s treatment at Plaza Medical Center, Respondent began to suspect that Plaza Medical Center was engaged in fraudulent billing practices. Respondent claims that he terminated his relationship with the Center shortly thereafter. There was no evidence presented in this case to establish that Respondent knowingly participated or acquiesced in fraudulent insurance billing. However, it was incumbent upon Respondent to see that accurate and complete records of his treatment of the patients were prepared and preserved.

10. Some of the medical records for Patient C.P. include a stamped signature of Respondent with the notation "typed but not proofed". Respondent testified that he did not prepare these pages and had not seen them prior to the initiation of this proceeding. Respondent argues that he is not responsible for those portions of the medical records which have not been positively identified as having been prepared by him. Even if those pages in the medical records which Respondent did not admit to preparing are disregarded, the evidence clearly established that Respondent has failed to ensure that adequate records have been maintained regarding his evaluation and treatment of Patient C.P.

11. The clear and convincing evidence presented in this case established that on or about March 20, 1984, Patient C.P. presented to Plaza Medical Center complaining of soreness in his hip and leg. Apparently, the Patient was referred to Plaza Medical Center by his attorney. During that visit, Patient C.P. related a history that included an accident on April 24, 1983 during which he was struck by a car while riding a bicycle. An Accidental Injury Report was filled out which noted that the Patient was experiencing memory loss, tension, irritability, mental dullness, and fatigue among other symptoms.

12. On March 22, 1984, Patient C.P. was examined at Plaza Medical Center by Michael Goodson, M.D., who prepared a Neurological Report. That Report noted that the Patient suffered arm, hip and pelvic injuries as a result of his accident. There is no indication of any other injuries or complaints by the Patient in that Report.

13. On March 26, 1984, C.P. was evaluated by Respondent. Respondent's Psychiatric Examination and Evaluation Report noted that the Patient was complaining of "light-headedness at times, irritability, dizziness, fatigue, blurring of vision at times, insomnia, a recent memory loss and difficulty in concentrating." Respondent diagnosed the Patient as suffering from "post-concussion syndrome".

14. Post-concussion syndrome is an amorphous diagnosis that can refer to a variety of complaints and symptoms that may occur after a patient has had a concussion and/or brain injury. There

are no commonly accepted objective neurological signs of post-concussion syndrome.

15. As a result of his evaluation, Respondent recommended that Patient C.P. receive "carbon dioxide treatments". At the hearing in this case, Respondent explained that the treatments are more accurately called carbogen and involve inhalation therapy with a mixture of roughly 20% carbon dioxide with 80% oxygen.[2]

16. The records that were presented in this case do not justify or substantiate the diagnosis of post-concussion syndrome nor do they justify the use of carbon dioxide treatment.

17. In treating post-concussion syndrome, it is prudent to identify the specific symptom(s) and their likely cause since the diagnosis is used for such a wide-range of conditions and symptoms could be caused by a number of different physiological sources or could even be psychiatric in nature. In this case, the Patient's accident had occurred almost one year prior to Respondent's evaluation. With an injury this old, a proper evaluation should have explored possibly serious medical causes for the Patient's complaints such as a subdural hematoma. There is no persuasive evidence that Respondent performed such an evaluation. However, it does not appear that Respondent's evaluation took into account the neurological examination that had been performed a couple of days before he first saw the Patient and it does not appear that Respondent had obtained an appropriate post medical history, family history or performed an adequate examination of the Patient. The billings for Dr.

Gilbert's March 26, 1984, exam was for a comprehensive examination with history. The records do not justify such a billing. Respondent's denial of any knowledge of the billing does not relieve him of responsibility where the bill was sent out under his name for a patient he saw.

18. The clear and convincing evidence in this case established that "carbogen" and/or carbon dioxide treatments are not taught in medical schools and are not generally accepted therapeutic modalities to treat "post-concussion syndrome". While Respondent claims there are other physicians who use carbon dioxide treatments for post-concussion syndrome, none of the six physicians whose depositions were accepted into evidence in this case had any direct experience with the treatments. Conflicting expert testimony was presented as to whether "carbogen" and/or carbon dioxide treatments are medically and physiologically sound.

19. In the late 1950s through the early 1970's, Respondent authored several articles and made a number of presentations in support of the use of carbon dioxide treatments for post-concussion syndrome. Respondent claims to have made oral presentations on this treatment approach as recently as 1983. The theory behind Respondent's support for such treatments is that carbon dioxide can increase cerebral blood flow which Respondent postulates can alleviate the histologic changes occurring in the post-cussional state. Respondent claims to have studied the use of such treatments in depth and reports favorable

results. Respondent's studies were not "double-blind" and do not scientifically validate the benefits. Respondent's experts concurred with the theory, however, none of them had ever utilized the treatment or studied it. Petitioner's experts contend that there is no scientific evidence that decreased profusion is a mechanism for post-concussion syndrome. They argue that, while the benefits of carbon dioxide treatments may have been an acceptable hypothesis at some earlier date, such treatments were not an acceptable modality for a reasonably prudent physician in the community at the time C.P. was treated at Plaza Medical Center. Petitioner did not present any scientific studies directly reflecting the claimed benefits of carbon dioxide treatments and/or refuting the result of the research published by Respondent regarding the benefits of these treatments. While it cannot be concluded from the record in this case that the use of carbon dioxide treatments is always below the standard of care expected of a reasonably prudent physician, such treatments should clearly not be utilized on an indiscriminate basis for any patient diagnosed as suffering from post-concussion syndrome. Because it is not a broadly accepted or recognized treatment and potentially could be harmful, a practitioner who chooses to use it should carefully select his patients and clearly document the Patient's condition and the justification for the treatment. Respondent failed to do so in connection with his recommendation for Patient C.P. He also failed to obtain an informal consent from the Patient prior to the initiation of the treatments.

20. The insurance billing records indicate that shortly after Respondent's recommendation, the Patient began receiving carbon dioxide treatments. Respondent disclaims any direct responsibility for administering of the treatments and down-plays his role in developing the Patient's treatment plan. Respondent's testimony regarding his involvement with Plaza Medical Center and his evaluation and treatment of Patient C.P. was vague and sometimes confusing. Respondent contends that he was merely a consultant to C.P.'s physicians and was not directly responsible for Patient C.P.'s treatment. However, it is clear that Respondent prepared a Psychiatric Examination and Evaluation and recommended carbon dioxide treatments which were administered.

21. There were several other physicians who treated C.P. at Plaza Medical Center. The exact role of each of these physicians is not entirely clear nor is it clear who was primarily responsible for the Patient's care. Respondent was the only physician whose notes include a recommendation for carbon dioxide treatments.

22. Subsequent to Respondent's recommendation, a report dated April 4, 1983 by Dr. Harold Freedman noted that the carbon dioxide treatments were to continue.

23. Respondent prepared a Final Examination and Evaluation of Patient C.P. on June 4, 1984. In his report, Respondent noted that the Patient's recent memory impairment was worse. There is no indication as to what efforts, if any, Respondent undertook to determine the cause of the Patient's deteriorating memory.

A typed version of the final report appears in the records bearing a stamp of Respondent's signature. Respondent denies seeing that version of the report and points out certain material variations between the typed and written versions. It is not clear when or where the typed version was prepared. The variations are of no consequence to this proceeding.

CONCLUSIONS OF LAW

24. The Division of Administrative Hearings has jurisdiction over the parties and the subject matter of this proceeding pursuant to Section 120.57(1), Florida Statutes.

25. Petitioner has the burden of proof in this license discipline case and must prove the allegations set forth in the Administrative Complaint by clear and convincing evidence, Ferris v. Turlington, 510 So.2d 292 (Fla. 1987); Evans Packing Company v. Department of Agriculture and Consumer Services, 550 So.2d 112, 116 (Fla. 1st DCA 1989); Pascale v. Department of Insurance, 525 So.2d 922 (Fla. 1st DCA 1988).

26. The nature of the clear and convincing evidence has been described in Slomowitz v. Walker, 429 So.2d 797, 800 (Fla. 4th DCA 1983), as follows:

> We therefore hold that clear and convincing evidence requires that the evidence must be found to be credible; the facts to which the witnesses testify must be precise and explicit and the witness must be lacking in confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established.

See also, Smith v. Department of Health and Rehabilitative Services, 522 So.2d 956, 958 (Fla. 1st DCA 1988), which quotes with approval the above-quoted language from Slomowitz, and adds, the following:

> "Clear and convincing evidence" is an intermediate standard of proof, more than the "preponderance of the evidence" standard used in most civil cases, and less than the "beyond a reasonable doubt" standard used in criminal cases. See State v. Graham, 240 So.2d 486 (Fla. 2d DCA 1970).

27. Pursuant to Section 458.331, Florida Statutes, the Board of Medicine is empowered to revoke, suspend or otherwise discipline the license of a registered physician who is found guilty of committing any of the offenses enumerated in Section 458.331(1), Florida Statutes. In determining whether a licensee has violated Section 458.331, Florida Statutes, as charged in an administrative complaint, one "must bear in mind that it is, in effect, a penal statute . . . this being true the statute must be strictly construed and no conduct is to be regarded as included within it that is not reasonably proscribed by it. Furthermore, if there are any ambiguities included such must be construed in favor of the . . . licensee." Lester v. Department of Professional and Occupational Regulations, 348 So.2d 923, 925 (Fla. 1st DCA 1977).

28. Disciplinary action with respect to a professional license is limited to offenses or facts alleged in the administrative complaint. Sternberg v. Department of Professional Regulation, Board of Medical Examiners, 465 So.2d 1324, 1325

(Fla. 1st DCA 1985); Kinney v. Department of State, 501 So.2d 129, 133 (Fla. 5th DCA 1987).

29. The Administrative Complaint in this case charges Respondent with violating Subsections (m) and (t) of Section 458.331(1), Florida Statutes. Those subsections authorize the Board to take disciplinary action against a physician's license as follows:

> (1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:
>
> * * *
>
> (m) failing to keep written medical records justifying the course of treatment of the Patient, including, but not limited to, Patient history; examination results; test results; records of drugs prescribed, dispensed or administered; and reports of consultations and hospitalizations
>
> * * *
>
> (t) gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances. The Board shall give great weight to the provision of s.766.102 when enforcing this Paragraph. As used in this Paragraph, "gross malpractice" or the "failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances" shall not be construed so as to require more than one instance, event, or act. Nothing in this Paragraph shall be construed to require that a physician be incompetent to practice medicine in order to be disciplined pursuant to this Paragraph.

30. Respondent has failed to keep adequate written medical records regarding his examination and treatment of Patient C.P.

As noted in Robertson v. Department of Professional Regulation, Board of Medicine, 574 So.2d 153 (Fla. 1st DCA 1990), a violation of Section 458.331(1)(m), may occur when medical records are so inadequate that "neutral third parties can (not) observe what transpired during the course of treatment of a patient. Even if Respondent was not the physician primarily responsible for this Patient, his records fail to meet this standard.

31. In addition, it is concluded that Respondent recommended a treatment modality that was not supported by the Patient's medical records and without adequately analyzing the Patient's condition.

32. In summary, the clear and convincing evidence in this case established that Respondent was guilty of violating Sections 458.331(1)(m) and (t), Florida Statutes, as alleged in Count I and II of the Administrative Complaint. Since, Petitioner did not carry its burden of proof with respect to Counts III and IV, those Counts should be dismissed.

33. The disciplinary guidelines of the Board of Medicine are found at Rule 61F6-20.001 (formerly 21M-20.001), Florida Administrative Code. Those Rules provide a range of penalties for a violation of Section 458.331(1)(m) from a reprimand to two (2) years suspension and an administrative fine from $250 to $5,000. For a violation of subsection (t), the Rules provide for a penalty from two (2) years probation to revocation of a license and an administrative fine from two hundred fifty dollars ($250) to five thousand dollars ($5,000).

34. Rule 61F6-20.001(3) provides as follows:

> (3) Aggravating and Mitigating Circumstances. Based upon consideration of aggravating and mitigating factors present in an individual case, the Board may deviate from the penalties recommended above. The Board shall consider as aggravating or mitigating factors the following:
>
> (a) Exposure of patient or public to injury or potential injury, physical or otherwise; none, slight, severe, or death;
> (b) Legal status at the time of the offense; no restraints or legal constraints;
> (c) The number of counts or separate offenses established;
> (d) The number of times the same offense or offenses have previously been committed by the licensee or applicant;
> (e) The disciplinary history of the applicant or licensee in any jurisdiction and the length or practice;
> (g) Any other relevant mitigating factors.

35. In this case, no evidence has been presented that any patient suffered any harm. Respondent has practiced for many years with no evidence of prior disciplinary action other than DOAH Case No. 93-5972 which was heard immediately prior to this case. While the evidence raises some questions regarding Plaza Medical Center and Respondent's involvement with it, no direct misconduct by Respondent has been proven other than as set forth above.

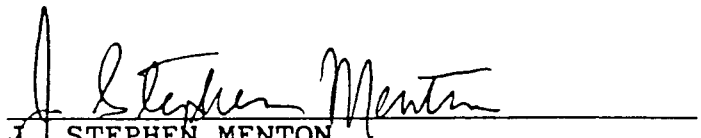
RECOMMENDATION

Based upon the foregoing Findings of Fact and Conclusions of Law, it is

RECOMMENDED that a Final Order be entered finding Respondent guilty of violating Sections 458.331(1)(m) and (t), Florida Statutes, as alleged in Counts I and II of the Administrative

Complaint, but dismissing Counts III and IV. As a penalty for the violations, Respondent's license to practice medicine should be placed on probation for two (2) years. In addition, an administrative fine in the amount of one thousand dollars ($1,000) should be imposed.

DONE AND RECOMMENDED this 24th day of May, 1995, in Tallahassee, Leon County, Florida.



J. STEPHEN MENTON
Hearing Officer
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-1550
(904)488-9675

Filed with the Clerk of the Division of Administrative Hearings this 24th day of May, 1995.

ENDNOTES

[1]The Amended Administrative Complaint was filed by the Department of Professional Regulation. Effective July 1, 1994, the Board of Medicine was transferred to the Agency for Health Care Administration pursuant to Section 20.42, Florida Statutes (1993).

[2]Respondent's testimony at hearing regarding the appropriate mixture of carbon dioxide and oxygen differs from the 50%-50% mixture that Respondent described in several of the articles that he authored and offered into evidence in support of this recommended treatment for Patient C.P. See, Gilbert, M.M., Post-Concussion Syndrome: Its Etiology and Treatment by Inhalation of Carbon Dioxide and Oxygen, Southern Medical Journal, Vol. 59, No. 10 p. 1155, 1158 (October 1966); Gilbert M. M., The Treatment of Post-Concussion Syndrome by Use of Carbon Dioxide-Oxygen Inhalations; Journal of the American Association of Inhalation Therapy, Vol 12, No. 6 p. 96, 98 (December 1967). No explanation for this discrepancy has been provided.

APPENDIX TO RECOMMENDED ORDER, CASE NO. 93-2858

Rulings on the proposed findings of fact submitted by the Petitioner:

1. Adopted in substance in findings of fact 1.
2. Adopted in substance in findings of fact 11.
3. Adopted in substance in findings of fact 12.
4. Adopted in substance in findings of fact 13.
5. Adopted in substance in findings of fact 13.
6. Subordinate to findings of fact 14.
7. Subordinate to findings of fact 15 and 21.
8. Subordinate to findings of fact 18 through 20.
9. Subordinate to findings of fact 23.
10. Adopted in substance in findings of fact 16 and 17.
11. Adopted in substance in findings of fact 16 and 17.
12. Adopted in substance in findings of fact 16 and 17.
13. Adopted in substance in findings of fact 18.
14. Rejected as vague and overly broad.
15. Rejected as vague and unnecessary.
16. Adopted in substance in findings of fact 18.
17. Subordinate to findings of fact 18.
18. Subordinate to findings of fact 17 through 21.

Rulings on the proposed findings of fact submitted by the Respondent:

1. The first two sentences are adopted in substance in findings of fact 1 and 3. The remainder of this proposal is subordinate to findings of fact 6 through 8 and 20.

2. Subordinate to findings of fact 15 and 20-22.

3. Rejected as unnecessary and not supported by competent, substantial evidence. While the medical records for Patient C.P. include references, and in some references, reports from these other physicians, no conclusions are reached herein as to the exact role of each of those physicians.

4. Rejected as constituting argument and speculation.

5. Rejected as overly broad and as constituting argument. This subject matter is addressed in findings of fact 17-19.

6. Subordinate to findings of fact 7, 9 and 23.

7. Subordinate to findings of fact 20.

8. Subordinate to findings of fact 8 through 10.

9. Addressed in the July 11, 1994 Order, the Preliminary Statement and in findings of fact 5.

10. Addressed in the Preliminary Statement and subordinate to findings of fact 5 through 9 and 23-24.

11. Addressed in the July 11, 1994 Order, the Preliminary Statement and subordinate to findings of fact 5 through 9.

12. Addressed in the Preliminary Statement.

13. Rejected as unnecessary.

14. Subordinate to findings of fact 18 and 19.

15. Subordinate to findings of fact 6, 13, 15-17, 20, 21 and 22.

16. Subordinate to findings of fact 6, 13, 15-17, 20, 21 and 22.

17. Subordinate to findings of fact 19.

18. Adopted in substance in findings of fact 18.

19. Subordinate to findings of fact 18 and 19.

20. Subordinate to findings of fact 17 and 18.

21. Addressed in the Preliminary Statement.

22. Subordinate to findings of fact 18 and 19.

23. Subordinate to findings of fact 18 and 19.

24. Subordinate to findings of fact 19.

25. Rejected as unnecessary.

26. Adopted in pertinent part in findings of fact 14 and 17.

Respondent's proposed findings of fact and conclusions of law includes a section entitled The Expert Testimony Presented. This section consists mostly of argument and summaries of testimony. No specific rulings are made in connection therewith.

COPIES FURNISHED:

Douglas M. Cook, Director
Agency for Health Care
Administration
2727 Mahan Drive
Tallahassee, FL 32308

Tom Wallace, Assistant Director
Agency for Health Care
Administration
The Atrium, Suite 301
325 John Knox Road
Tallahassee, FL 32303

Arthur B. Skafidas, Esq.
Monica L. Felder
Department of Business
and Professional Regulation
Suite 60
1940 North Monroe Street
Tallahassee, Florida 32399-0792

Joseph Paglino, Esquire
Suite 301
11601 Biscayne Boulevard
North Miami, Florida 33181

NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions to this Recommended Order. All agencies allow each party at least 10 days in which to submit written exceptions. Some agencies allow a larger period within which to submit written exceptions. You should contact the agency that will issue the final order in this case concerning agency rules on the deadline for filing exceptions to this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the final order in this case.

STATE OF FLORIDA
DEPARTMENT OF PROFESSIONAL REGULATION
AGENCY FOR HEALTH CARE ADMINISTRATION

DEPARTMENT OF PROFESSIONAL REGULATION,

Petitioner,

vs.

MICHAEL M. GILBERT, M.D.,

Respondent.
_____/

DOAH CASE NO. 93-2585
DBPR CASE NO. 93-0106456

RESPONDENT'S EXCEPTIONS TO RECOMMENDED ORDER, FINDINGS OF FACT AND CONCLUSIONS OF LAW

Respondent, Michael M. Gilbert, M.D., files these, his exceptions to the Recommended Order dated 24 May 1995 and served on 26 May 1995.

Appearances of Counsel for the Parties:

For Petitioner: Arthur Skafidas, Esq./Monica Feldman, Esq.
Dept. of Business & Professional Regulation
1940 North Monroe Street
Tallahassee, Florida 32399-0792

For Respondent: Joseph S. Paglino, Esq.
11601 Biscayne Blvd., Suite 301
North Miami, Florida 33181

THE CHARGES AGAINST RESPONDENT

Respondent was charged with violations in Four (4) Counts of an Amended Administrative Complaint. Counts 1 and

2 refer to Patient #1, C.P. Counts 3 and 4 refer to Patient #2, E.R. The Charges and exceptions to the Recommended Order are treated separately as to each "Patient".

I

PETITIONER'S CHARGES AGAINST
RESPONDENT AS TO PATIENT #1, C.P.

Count I charged Respondent with failing to keep written medical records as to Patient # 1, C.P., in violation of Section 458.331(1)(m), Florida Statutes, and failing to practice medicine with the acceptable standard of care in violation of s. 458.331(1)(t).

Count II charged Respondent with failure to keep proper medical records in violation of s. 458.331(1)(m), and with violating Section 458.331(1)(t), Florida Statutes, by committing gross malpractice or the failure to practice medicine with the acceptable standard of care.

s. 458.331(m), F.S. reads as follows:

> Failing to keep written medical records justifying the course of treatment of the Patient, including, but not limited to, Patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

s. 458.331(1)(t) reads as follows:

> Gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under

similar conditions and circumstances. The board shall give great weight to the provisions of s. 766.102 when enforcing this Paragraph. As used in this Paragraph, "repeated malpractice" includes, but is not limited to three or more claims for medical malpractice within the previous 5-year period resulting in indemnities being paid in excess of $10,000.00 each to the claimant in a judgment or settlement and which incidents involved negligent conduct by the physician. As used in this Paragraph, "gross malpractice" or "the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances," shall not be construed so as to require more than one instance, event, or act. Nothing in this Paragraph shall be construed to require that a physician be incompetent to practice medicine in order to be disciplined pursuant to this Paragraph.

THE PERTINENT ALLEGATIONS AS TO PATIENT #1, C.P.

The pertinent allegations supporting Counts 1 and 2, as to Patient #1, C.P., are set forth in Paragraphs 3 through 6 of the Amended Complaint, as follows:

3. On or about March 26, 1984, until on or about June 4, 1984, Respondent treated Patient #1 for, but not limited to, pain in the right hip and right leg. On or about March 26, 1984, Respondent diagnosed Patient #1 as suffering from Post-Concussion Syndrome.

4. Respondent failed to keep written records of Patient #1's medical history, mental status, and physical examinations. Respondent's medical records to not justify the diagnosis of Post-Concussion Syndrome.

5. Respondent recommended and treated Patient #1's condition with Carbon Dioxide treatments.

Carbon Dioxide treatments are not accepted as a therapeutic modality for Patient #1's condition, Post-Concussion Syndrome.

6. Respondent failed to practice medicine with that level of care, skill and treatment which a reasonably prudent similar physician recognizes as acceptable under similar conditions and circumstances, in that Respondent treated Patient #1 with Carbon Dioxide treatments; and/or Respondent misdiagnosed the Patient as suffering from Post-Concussion Syndrome.

RESPONDENT'S EXCEPTIONS TO THE RECOMMENDED ORDER

AS TO PATIENT # 1 - C.P.

1. Respondent takes exception to any finding or conclusion of law that on or about March 26, 1984, until on or about June 4, 1984, Respondent treated Patient #1 for, but not limited to, pain in the right hip and right leg.

2. Respondent takes exception to any finding or conclusion of law that on or about March 26, 1984, Respondent diagnosed Patient #1 as suffering from Post-Concussion Syndrome.

3. Respondent takes exception to any finding or conclusion of law that he failed to keep required written records of Patient #1's medical history, mental status, and physical examinations.

4. Respondent takes exception to any finding or conclusion of law that Respondent's or other applicable

medical records did not justify the diagnosis of Post-Concussion Syndrome.

5. Respondent takes exception to any finding or conclusion of law that he improperly recommended and/or treated Patient #1's condition with Carbon Dioxide treatments.

6. Respondent takes exception to any finding or conclusion of law that Carbon Dioxide treatments are not accepted as a therapeutic modality for Patient #1's condition, Post-Concussion Syndrome.

7. Respondent takes exception to any finding or conclusion of law that he failed to practice medicine with that level of care, skill and treatment which a reasonably prudent similar physician recognizes as acceptable under similar conditions and circumstances, in that Respondent treated Patient #1 with Carbon Dioxide treatments; and/or

8. Respondent takes exception to any finding or conclusion of law that he misdiagnosed Patient # 1 as suffering from Post-Concussion Syndrome.

9. Respondent takes exception to any finding or conclusion of law that he:

(a) failed to practice medicine with the

acceptable standard of care, as to Patient # 1, in violation of s. 458.331(1)(t), or,

(b) failed to keep proper medical records in violation of s. 458.331(1)(m), or in violation of Section 458.331(1)(t), Florida Statutes.

10. Respondent takes exception to any finding or conclusion of law that he should be disciplined for any of the matters set forth in the Administrative Complaint, as to Patient # 1.

11. Respondent takes exception to any finding or conclusion of law that he should be subjected to any of the punishments recommended in the Recommended Order.

12. Respondent takes exception to any finding or conclusion of law that any of his affirmative defenses to the Administrative Complaint are not legally sufficient or sufficient to cause dismissal of the Administrative Complaint.

13. Respondent takes exception to any finding or conclusion of law that the Administrative Complaint should not be dismissed on the grounds asserted by Respondent in his Motions and/or Memoranda of law.

14. Respondent takes exception to any finding or conclusion of law that he should not be awarded a

reasonable attorneys fee for the defense of the Administrative Complaint filed against him.

15. Respondent takes exception to the Hearing Officer's rejection of each of Respondent's Proposed Findings Of Facts which the Hearing Officer did not adopt in his Recommended Order.

16. Respondent takes exception to the Hearing Officer's rejection of each of the Respondent's Proposed Conclusions Of Law, which the Hearing Officer did not adopt in his Recommended Order as to Patient #1, C.P.

17. Respondent takes exception to findings of conclusions of law in the Hearing Officers Recommended Order, insofar as the Recommended Order finds that Petitioner proved the essential elements of the charge as to Patient # 1, in the Administrative Complaint which it brought against Respondent.

II

PETITIONER'S CHARGES AGAINST
RESPONDENT AS TO PATIENT # 2, B.R.

Count 3 of the Administrative Complaint charged that Respondent failed to keep written medical records justifying the course of treatment of Patient #2

Count 4 of the Administrative Complaint charged

that Respondent failed to practice medicine with that level of care, skill and treatment which a reasonably prudent similar physician recognizes as acceptable under similar conditions and circumstances, infra.

III

RESPONDENT'S EXCEPTIONS TO THE RECOMMENDED ORDER AS TO PATIENT #2, E. R.

The charges against Respondent as to Patient E.R., were dismissed by the Hearing Officer, and are not, therefore, in issue in this Objection, except as to Respondent's objection to the Hearing Officer's denial of an attorneys fee award to Respondent for defending against Counts III and IV.

IV

RESPONDENT'S ADOPTION AND INCORPORATION BY REFERENCE HEREIN OF HIS PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

Respondent, Michael M. Gilbert, hereby adopts and incorporates by reference herein, as though fully set forth herein, his Proposed Findings Of Fact And Conclusions Of Law, filed in this cause heretofore, in support of his Exceptions To The Recommended Order of the Hearing Officer, as to Patient C.P., Counts I and II.

V

RESPONDENT'S REQUEST FOR HEARING ON HIS EXCEPTIONS TO THE RECOMMENDED ORDER

Respondent respectfully requests a Hearing before the Agency Of Health Care Administration or other applicable Board, on his Exceptions to the Recommended Order of the Hearing Officer.

VI

RESPONDENT'S POSITION AS TO RETROACTIVE DISCIPLINE TO THE DATE OF THE ADMINISTRATIVE COMPLAINT

Respondent, takes issue with prospective discipline in this case. It would appear appropriate, under these circumstances, that assuming any punishement is appropriate, that it be retroactive to the date of the filing of the Administrative Complaint in this cause.

Law Office Of Jos. S. Paglino
11601 Biscayne Blvd. Suite 301
North Miami, Florida 33181
Tel. (305) 758-8017

By /s/

CERTIFICATE OF SERVICE

IT IS HEREBY CERTIFIED that the original of the foregoing was furnished by mail this 27 day of May, 1995, to the Hon. David Cook, Director, Agency For Health Care Administration, 2727 Mahan Drive, Tallahassee, Florida 32308, and, to the Clerk of the Board, Agency For Health Care Administration, 2727 Mahan Drive, Tallahassee, Florida 32308, and, to Monica L. Felder, Esq. & Arthur Skafidas, Esq., Co-Counsel for Petitioner, Department of Business & Professional Regulation, 1940 North Monroe Street, Tallahassee, Florida 32399-0792.

/s/

Jos. S. Paglino, Esq.

STATE OF FLORIDA
DEPARTMENT OF PROFESSIONAL REGULATION
BOARD OF MEDICINE

DEPARTMENT OF PROFESSIONAL REGULATION,

Petitioner,

vs. Case No. 0106456

MICHAEL GILBERT, M.D.

Respondent.
_____/

AMENDED ADMINISTRATIVE COMPLAINT

COMES NOW, the Petitioner, Department of Professional Regulation, hereinafter referred to as "Petitioner", and files this Amended Administrative Complaint before the Board of Medicine against MICHAEL GILBERT, M.D., hereinafter referred to as "Respondent", and alleges:

1. Petitioner is the state agency charged with regulating the practice of medicine pursuant to Section 20.30, Florida Statutes, Chapter 455, Florida Statutes and Chapter 458, Florida Statutes.

2. Respondent is and has been at all times material hereto a licensed physician in the State of Florida, having been issued license number ME 0004260. Respondent's last known address is 1200 Biscayne Boulevard, Miami, Florida 33152.

Facts Relating to Patient #1

3. On or about March 26, 1984, until on or about June 4, 1984, Respondent treated Patient #1 for, but not limited to, pain in the right hip and right leg. On or about March 26, 1984, Respondent diagnosed Patient #1 as suffering from Post-Concussion

Syndrome.

4. Respondent failed to keep written records of Patient #1's medical history, mental status, and physical examinations. Respondent's medical records do not justify the diagnosis of Post-Concussion Syndrome.

5. Respondent recommended and treated Patient #1's condition with carbon dioxide treatments. Carbon dioxide treatments are not accepted as a therapeutic modality for Patient #1's condition, Post-Concussion Syndrome.

6. Respondent failed to practice medicine with that level of care, skill and treatment which a reasonably prudent similar physician recognizes as acceptable under similar conditions and circumstances, in that Respondent treated Patient #1 with carbon dioxide treatments; and/or Respondent misdiagnosed the patient as suffering from Post-Concussion Syndrome.

COUNT ONE

7. Petitioner realleges and incorporates paragraphs one (1) through six (6) as if fully set forth herein this Count One.

8. Respondent failed to keep written medical records justifying the course of treatment of Patient #1.

9. Based on the preceding allegations, Respondent violated Section 458.331(1)(m), Florida Statutes, in that Respondent failed to keep written medical records justifying the course of treatment of the patient, including, but not limited to, patient histories, examination results, and test results.

COUNT TWO

10. Petitioner realleges and incorporates paragraphs one (1)

through six (6) and eight (8) as if fully set forth herein this Count Two.

11. Based on the preceding allegations, Respondent violated Section 458.331(1)(t), Florida Statutes, in that Respondent is guilty of gross malpractice or the failure to practice medicine, with the level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

Facts Relating to Patient #2

12. From on or about September 28, 1987, until on or about October 3, 1987, Respondent treated Patient #2 for complaints of headaches, dizzy spells, postural syncopy, and pain in the back, neck, and right ankle, among other conditions not named here. Respondent diagnosed the patient as suffering from Post-Concussion Syndrome.

13. Respondent's medical records failed to address Patient #2's past medical and social history.

14. On or about September 28, 1987, Respondent performed a neurological evaluation of Patient #2. The only negative clinical finding was a 4 + postural syncopy. Said neurological examination was incomplete and the clinical findings are not explained by the Respondent's diagnosis of Post-Concussion Syndrome for Patient #2.

15. On or about October 3, 1987, Respondent performed an EEG Test on Patient #2. Respondent's records did not adequately document the need for the EEG testing.

16. Respondent's evaluation of said EEG test was unacceptable and below the standard of care.

COUNT THREE

17. Petitioner realleges and incorporates paragraphs one (1), two (2), and twelve (12) through fifteen (15) as if fully set forth herein this Count Three.

18. Respondent failed to keep written medical records justifying the course of treatment of Patient #2 including, but not limited to the following: Respondent's records of Patient #2 failed to provide adequate medical and social history; Respondent's records of Patient #2 failed to justify any diagnosis of Patient #2; and Respondent's records of Patient #2 failed to justify the need for the EEG test on Patient #2.

19. Based on the preceding allegations, Respondent violated Section 458.331(1)(m), Florida Statutes, in that Respondent failed to keep written medical records justifying the course of treatment of the patient, including, but not limited to, patient histories, examination results, and test results.

COUNT FOUR

20. Petitioner realleges and incorporates paragraphs thirteen (13) through sixteen (16) as if fully set forth herein this Count Four.

21. Respondent failed to practice medicine with that level of care, skill and treatment which a reasonably prudent similar physician recognizes as acceptable under similar conditions and circumstances.

22. Based on the preceding allegations, Respondent violated Section 458.331(1)(t), Florida Statutes, in that Respondent is guilty of gross malpractice or the failure to practice medicine,

with the level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

WHEREFORE, Petitioner respectfully requests the Board of Medicine enter an Order imposing one or more of the following penalties: revocation or suspension of the Respondent's license, restriction of the Respondent's practice, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on probation, and/or any other relief that the Board deems appropriate.

SIGNED this 25 day of August, 1992.

George Stuart,
Secretary

BY: Larry G. McPherson, Jr.
Chief Medical Attorney

COUNSEL FOR DEPARTMENT:

Larry G. McPherson, Jr.
Chief Medical Attorney
Fla. Bar No. 0788643
Department of Professional
Regulation
1940 North Monroe Street
Tallahassee, Florida 32399-0792
(904) 488-0062

FILED
Department of Professional Regulation
AGENCY CLERK

CLERK

DATE 8-26-92

LGM/RC/ecs
PCP: 8/14/92

Basisht, Murray, Rodriguez

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
BOARD OF MEDICINE

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

AHCA CASE NO. 0106456
DOAH CASE NO. 93-2858

v.

MICHAEL M. GILBERT, M.D.,

Respondent,
_____/

PETITIONER'S RESPONSE TO RESPONDENT'S EXCEPTIONS TO RECOMMENDED ORDER

COMES NOW, the Agency for Health Care Administration, formerly the Department of Business and Professional Regulation, the Petitioner, and submits this Response in opposition to Respondent's Exceptions to Recommended Order. The Petitioner respectfully requests that the Board of Medicine reject Respondent's Exceptions and as grounds would state:

1. A formal hearing regarding this matter was held on May 25-26, 1994. On July 21, 1994, Petitioner filed its Proposed Recommended Order. Respondent timely filed his Proposed Findings of Fact and Conclusions of Law. On May 24, 1995, the Hearing Officer issued a Recommended Order finding Respondent guilty of the violations in Counts I and II of the Amended Administrative Complaint, a failure to practice with an acceptable level of care and a failure to maintain written medical records justifying the course of treatment of the patient, and recommended that Respondent

be fined $1,000 and that Respondent's license to practice medicine be placed on probation for a period of two (2) years. The Hearing Officer recommended dismissal of Counts III and IV of the Amended Administrative Complaint. On May 30, 1995, Respondent timely filed these Exceptions to Recommended Order, Findings of Fact and Conclusions of Law.

2. This Honorable Board should not reject the findings of fact entered by the Hearing Officer unless it finds that there is no competent, substantial evidence to support those findings of fact. See McDonald v. Dept. of Banking and Finance, 346 So.2d 569 (Fla. 1st DCA 1977).

3. Respondent takes exception to any findings of fact or conclusions of law that are not favorable to Respondent. The Board should reject these exceptions because they are conclusory, subordinate, cumulative, immaterial, or unnecessary.

4. Further, Respondent's general exceptions are not specific enough for the Board to consider. Rule 59R-18.004, Florida Administrative Code, allows the Board to summarily reject exceptions which do not set forth with reasonable specificity the specific findings of fact or conclusions of law at issue and the basis for the exception.

5. Petitioner's proposed findings of fact, incorporated in the Hearing Officer's Recommended Order, are supported by the following competent, substantial evidence:

a. Respondent is, and has been at all times material hereto, a licensed physician, having been issued license number ME 0004260

by the State of Florida. (Pet. Exh. 1, p. 1; Pet. Exh. 2, p. 2; Pet. Exh. 8, p. 1)

b. On March 20, 1984, Patient C.P. presented to Plaza Medical Center complaining of soreness in his hip and leg. (Pet. Exh. 12, p. 3)

c. On March 22, 1984, Patient C.P. was examined by Michael Goodson, M.D.. Patient C.P. related a history that included an accident that occurred on April 24, 1983, during which a bicycle he was riding was struck by a vehicle. (Pet. Exh. 12, p. 4)

d. On March 26, 1984, Patient C.P. was evaluated by Respondent. (Pet. Exh. 12, pp. 9-11)

e. On March 26, 1984, Respondent diagnosed Patient C.P. as suffering from Post-Concussion Syndrome. (Pet. Exh. 9, pp. 12, 17-18; Pet. Exh. 10, p. 64; Pet. Exh. 10, depo exh. March 29, 1994, Friend, M.D. letter to Skafidas, pp. 2-3)

f. Post-Concussion Syndrome is a group of symptoms that occur after a patient has had a concussion, which begins with a loss of consciousness, usually for a brief period of time. (Pet. Exh. 10, pp. 73-74)

g. Respondent recommended and treated Patient C.P.'s condition, Post-Concussion Syndrome, with Carbon Dioxide treatments. (Pet. Exh. 8, pp. 1, 4; Pet. Exh. 9, pp. 17-18; Pet. Exh. 10, p. 64; Pet. Exh. 10, depo exh. March 29, 1994, Friend, M.D. letter to Skafidas, pp. 2-3; Pet. Exh. 12, 9-11; Transcript, pp. 211, 216)

h. Carbon dioxide treatments are not accepted as a therapeutic modality to treat Post-Concussion Syndrome. (Pet. Exh. 9, pp. 19-23, 113-115; Pet. Exh. 10, pp. 35, 38-39; Pet. Exh. 10, depo exh. March 29, 1994, Friend, M.D. letter to Skafidas, pp. 2-3)

i. Following Respondent's recommended course of treatment for Patient C.P.'s Post-Concussion Syndrome, administration of carbon dioxide therapy, Patient C.P.'s memory impairment worsened. (Pet. Exh. 12, pp. 34-35; Transcript, p. 257)

j. Respondent failed to keep adequate written medical records on Patient C.P., including, but not limited to, medical history, mental status, and physical examinations. (Pet. Exh. 9, pp. 14, 16; Pet. Exh. 10, depo exh. March 29, 1994, Friend, M.D. letter to Skafidas, p. 4; Transcript, pp. 212-214, 216-219)

k. Respondent's written medical records for Patient C.P. do not justify or substantiate the diagnosis of Post-Concussion Syndrome. (Pet. Exh. 9, p. 17; Pet. Exh. 10, depo exh. March 29, 1994, Friend, M.D. letter to Skafidas, pp. 2-4)

l. Respondent failed to keep written medical records of Patient C.P. justifying the course of treatment, carbon dioxide therapy for Post-Concussion Syndrome. (Pet. Exh. 9, p. 19; Pet. Exh. 10, p. 40; Pet. Exh. 10, depo exh. March 29, 1994, Friend, M.D. letter to Skafidas, pp. 2-4; Transcript, pp. 212-214, 216-219)

m. The use of carbon dioxide therapy to treat Post-Concussion Syndrome is not taught in medical schools. (Res. Exh. 2, p. 13; Res. Exh. 3, pp. 15, 19; Res. Exh. 4, p. 37)

n. The use of carbon dioxide to treat Post-Concussion Syndrome is not discussed at medical conferences. (Pet. Exh. 9, p. 20)

o. None of Respondent's expert witnesses have hospital privileges to administer carbon dioxide therapy to treat Post-Concussion Syndrome. (Res. Exh. 3, p. 9; Res. Exh. 4, p. 12)

p. None of Respondent's expert witnesses use or have ever used carbon dioxide to treat Post-Concussion Syndrome. (Res. Exh. 2, p. 15; Res. Exh. 3, pp. 15, 19; Res. Exh. 4, p. 16)

q. None of Respondent's expert witnesses know of any other physicians, other than Respondent, who use carbon dioxide to treat Post-Concussion Syndrome. (Res. Exh. 2, pp. 33, 35-36; Res. Exh. 3, p. 20; Res. Exh. 4, pp. 17, 19)

r. Respondent failed to practice medicine with an acceptable level of care, skill, and treatment which a reasonably prudent similar physician recognizes as acceptable under similar conditions and circumstances, in that Respondent treated Patient C.P. with carbon dioxide treatment; and/or Respondent misdiagnosed Patient C.P. as suffering Post-Concussion Syndrome. (Pet. Exh. 9, pp. 19-23, 113-115; Pet. Exh. 10, pp. 35, 38-39; Pet. Exh. 10, depo exh. March 29, 1994, Friend, M.D. letter to Skafidas, pp. 2-4)

6. Based on the evidence cited in the preceding paragraphs, it is clear Respondent's general exceptions should be rejected.

7. It is the Hearing Officer's function to consider all evidence presented, resolve conflicts, judge credibility of witnesses, draw permissible inferences from the evidence, and reach

ultimate findings of fact based on competent, substantial evidence. See Goss v. District School Bd. of St. Johns County, 601 So.2d 1232 (Fla. 5th DCA 1992). Clearly, the Hearing Officer's findings were supported by competent, substantial evidence.

8. It is the Hearing Officer's function in an administrative proceeding to act as trier of fact and the Hearing Officer is privileged to weigh and reject conflicting evidence. See Cenac v. Florida State Bd. of Accountancy, 399 So.2d 1013 (1981).

9. In response to Respondent's arguments that he should be awarded reasonable attorney fees and costs in this matter, Petitioner asserts that since Respondent is not a prevailing small business party as defined by Section 57.111(3)(c), Florida Statutes, Respondent is not entitled to any fees or costs. Respondent's request is clearly not ripe since the Board has not yet entered a Final Order in this matter.

10. Respondent argues that any discipline imposed should be retroactive to the date of the filing of the Administrative Complaint in this cause. Respondent fails to cite to any authority to support that position. Respondent's argument in this regard is offensive to traditional notions of due process and justice and should be rejected.

WHEREFORE, Petitioner files this Response to Respondent's Exceptions to Recommended Order and requests the Board DENY Respondent's Exceptions for the reasons stated herein and at the formal hearing.

Respectfully submitted,

Arthur B. Skafidas
Senior Attorney
Florida Bar No. 0867160
Agency for Health Care
Administration
Northwood Centre
1940 North Monroe Street,
Suite 60
Tallahassee, FL 32399-0792

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Petitioner's Response to Respondent's Exceptions to Recommended Order has been furnished by U.S. Mail to Joseph Paglino, 11601 Biscayne Boulevard, Suite 301, North Miami, Florida 33181 this 12th day of June, 1995.

Arthur B. Skafidas
Senior Attorney

STATE OF FLORIDA
DEPARTMENT OF PROFESSIONAL REGULATION
BOARD OF MEDICINE

DEPARTMENT OF PROFESSIONAL REGULATION,

Petitioner, CASE NO. 0106456

v.

MICHAEL GILBERT, M.D.

Respondent.
_____/

ADMINISTRATIVE COMPLAINT

COMES NOW, the Petitioner, Department of Professional Regulation, hereinafter referred to as "Petitioner", and files this Administrative Complaint before the Board of Medicine against MICHAEL GILBERT, M.D., hereinafter referred to as "Respondent", and alleges:

1. Petitioner is the state agency charged with regulating the practice of medicine pursuant to Section 20.30, Florida Statutes, Chapter 455, Florida Statutes, and Chapter 458, Florida Statutes.

2. Respondent is and has been at all times material hereto a licensed physician in the State of Florida, having been issued license number ME 0004260. Respondent's last known address is 1200 Biscayne Boulevard, Miami, Florida 33152.

Facts Relating to Patient #1

3. On or about March 26, 1984, until on or about June 4, 1984, Respondent treated Patient #1 for, but not limited to, pain in the right hip and right leg. On or about March 26,1984,

Respondent diagnosed Patient #1 as suffering from Post-Concussion Syndrome.

4. Respondent failed to keep adequate written records of Patient #1's medical history, mental status, and physical examinations. Respondent's medical records do not justify the diagnosis of Post-Concussion Syndrome.

5. Respondent recommended and treated Patient #1's condition with carbon dioxide treatments. Carbon dioxide treatments are not accepted as a therapeutic modality for Patient #1's condition, Post-Concussion Syndrome.

6. Respondent failed to practice medicine with that level of care, skill and treatment which a reasonably prudent similar physician recognizes as acceptable under similar conditions and circumstances, in that Respondent treated Patient #1 with carbon dioxide treatments; and/or Respondent misdiagnosed the patient as suffering from Post-Concussion Syndrome.

7. From on or about March 27, 1984, until on or about May 19, 1984, Patient #1 was referred to three different specialists, a neurologist, a general practitioner, and an orthopedic surgeon, on seven different occasions.

8. Although Respondent referred Patient #1 to the specialists mentioned above, Respondent failed to appropriately respond to the information received from those consultants in a manner which would lead to the formulation of an appropriate diagnosis for the patient, and the implementation of an appropriate treatment plan for the patient. The failure to so

respond constitutes a failure to practice medicine with that level of care, skill and treatment which a reasonably prudent similar physician recognizes as acceptable under similar conditions and circumstances.

COUNT ONE

9. Petitioner realleges and incorporates paragraphs one (1) through five (5) and seven (7) as if fully set forth herein this Count One.

10. Respondent failed to keep written medical records justifying the course of treatment of Patient #1.

11. Based on the preceding allegations, Respondent violated Section 458.331(1)(m), Florida Statutes, in that Respondent failed to keep written medical records justifying the course of treatment of the patient, including, but not limited to, patient histories, examination results, and test results.

COUNT TWO

12. Petitioner realleges and incorporates paragraphs one (1) through and eight (8) and ten (10) as if fully set forth herein this Count Two.

13. Based on the preceding allegations, Respondent violated Section 458.331(1)(t), Florida Statutes, in that Respondent is guilty of gross malpractice or the failure to practice medicine, with the level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

Facts Relating To Patient #2

14. From on or about September 28, 1987, until on or about October 3, 1987, Respondent treated Patient #2 for complaints of headaches, dizzy spells, postural syncopy, and pain in the back, neck, and right ankle, among other conditions not named here. Respondent diagnosed the patient as suffering from Post-Concussion Syndrome.

15. Respondent's medical records failed to address Patient #2's past medical and social history.

16. On or about September 28, 1987, Respondent performed a neurological evaluation of Patient #2. The only negative clinical finding was a 4 + postural syncopy. Said neurological examination was incomplete and the clinical findings are not explained by the Respondent's diagnosis of Post Concussion Syndrome for Patient #2.

17. On or about October 3, 1987, Respondent performed an EEG Test on Patient #2. Respondent's records did not adequately document the need for the EEG testing.

18. Respondent's evaluation of said EEG test was unacceptable and below the standard of care.

COUNT THREE

19. Petitioner realleges and incorporates paragraphs one (1), two (2), and fourteen (14) through seventeen (17) as if fully set forth herein this Count Three.

20. Respondent failed to keep written medical records justifying the course of treatment of Patient #2 including, but not limited to the following: Respondent's records of Patient #2

failed to provide an adequate medical and social history; Respondent's records of Patient #2 failed to justify any diagnosis of Patient #2; and Respondent's records of Patient #2 failed to justify the need for the EEG test of Patient #2.

21. Based on the preceding allegations, Respondent violated Section 458.331(1)(m), Florida Statutes, in that Respondent failed to keep written medical records justifying the course of treatment of the patient, including, but not limited to, patient histories, examination results, and test results.

COUNT FOUR

22. Petitioner realleges and incorporates paragraphs fifteen (15) through eighteen (18) as if fully set forth herein this Count Four.

23. Respondent failed to practice medicine with that level of care, skill and treatment which a reasonably prudent similar physician recognizes as acceptable under similar conditions and circumstances.

24. Based on the preceding allegations, Respondent violated Section 458.331(1)(t), Florida Statutes, in that he is guilty of gross or repeated malpractice or the failure to practice medicine, with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

WHEREFORE, Petitioner respectfully requests the Board of Medicine enter an Order imposing one or more of the following penalties: revocation or suspension of the Respondent's license,

restriction of the Respondent's practice, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on probation, and/or any other relief that the Board deems appropriate.

SIGNED this 15th day of February, 1991.

George Stuart, Secretary

By: Stephanie A. Daniel
Chief Medical Attorney

COUNSEL FOR DEPARTMENT:

Larry G. McPherson, Jr.
Senior Attorney
Florida Bar No. 0788643
Dept. of Professional Regulation
1940 N. Monroe Street, Ste. 60
Tallahassee, Florida 32399-0792
(904) 488-0062

PCP: 1-28-91
Burt, Campbell, Wertheimer

FILED
Department of Professional Regulation
AGENCY CLERK

CLERK

DATE 2-15-91

MEMORANDUM

TO: Compliance Tracking File

FROM: Compliance Management Unit

DATE: Friday, July 7, 2006

SUBJECT: Closing Document

Due to the history and age of this file, it is apparent that it should have been closed; however, no closing order or notice of completion was entered into this file during the normal course of business. In the absence of this documentation, this memorandum will serve as the official closing document and terminates compliance tracking activities for the attached Final Order.